

Office of External Affairs Office

FACT SHEET

ENSURING AN EFFECTIVE TRANSITION OF DUAL ELIGIBLES FROM MEDICAID TO MEDICARE PART D

Beginning January 1, 2006, responsibility for the prescription drug coverage for over 6 million low-income Medicare beneficiaries who also are enrolled in Medicaid shifts from the states to the federal government consistent with the Medicare Modernization Act of 2003. These beneficiaries, referred to as the full-benefit dual eligibles, will qualify for Medicare prescription drug coverage with low or no premiums and co-payments of a few dollars.

CMS recognizes the enormity of this transition from Medicaid drug coverage to Medicare and has been working intensively with many partners in and out of government to ensure that the transition process for these beneficiaries is as seamless and efficient as possible. The most important goal of this transition is to ensure full-benefit dual eligible beneficiaries will get the prescription drug coverage they need as of January 1, 2006.

CMS is committed to accomplishing the following two key objectives to ensure a safe and appropriate transition of the dual eligible population from Medicaid to Medicare Prescription Drug Coverage:

I. Providing comprehensive coverage and high quality prescription drug coverage plans for all people with Medicare, but especially for the dually eligible population, who often take a number of prescriptions to manage one or more chronic conditions. To achieve this objective, CMS has taken the following steps:

A. Robust Formulary Requirements – CMS developed a set of checks and oversight activities to ensure that prescription drug plans offer a comprehensive benefit that reflects best practices in the pharmacy industry, as well as current treatment standards. Plan formularies must recognize the special needs of particular types of beneficiaries, such as mental health patients, those with HIV/AIDS, those living in nursing homes, people with disabilities, and other beneficiaries who are stabilized on certain drug regimens. CMS has reviewed these formularies and benefit structures to verify that plans are in compliance with the following critical requirements:

1. Multiple drugs in each class – minimum statutory requirement is that a formulary must include at least two drugs in each approved category and class

(unless only one drug is available for a particular category or class). In addition, we have required that each plan's formulary include all or substantially all drugs in each of the following key categories: antidepressants, antipsychotics, anticonvulsants, anticancer drugs, immunosuppressants and antiretrovirals for treating HIV/AIDS.

2. Each Medicare prescription drug plan's formulary was developed and reviewed by the plan's pharmacy and therapeutics committee. Each must be consistent with widely used industry best practices.

3. CMS compared the prescription drug plans' use of benefit management tools to the way these tools are used in existing drug plans to ensure that they are being applied in a clinically appropriate fashion.

B. Transition Guidance – CMS has required each Medicare prescription drug plan to establish an appropriate transition process for all new enrollees. All of these transition plans include at least a one-time fill of a prescription drug excluded from the plan's formulary in order to accommodate situations in which a beneficiary presents at a participating pharmacy with a prescription he or she has previously filled but that is not on the formulary. Each transition process addresses the plan sponsor's method of educating both beneficiaries and providers to ensure a safe and complete accommodation of an individual's medical needs with the plan's formulary. Additionally, CMS recommends that this transition process address unplanned transitions as individuals change treatment settings due to a change in their level of care.

C. Exceptions Procedures – CMS has developed exceptions procedures designed to ensure that enrollees receive prompt decisions regarding whether medications are medically necessary. For example, if an enrollee requests a non-formulary drug, the plan must make its decision as expeditiously as the enrollee's health condition requires after it receives the request, but no later than 24 hours for an expedited coverage determination or 72 hours for a standard coverage determination.

D. Protecting Dual Eligible Residents of Long-Term Care Facilities - CMS established specific protections for beneficiaries who live in long-term care facilities and get their prescriptions from long-term care pharmacies. A condition of participation requires every plan to provide in-network coverage to all enrollees who live in any nursing home in its region. Each plan will be notified as to which of their enrollees live in a long-term care setting, which will help the plans and the facilities prepare for any potential changes to the beneficiary's drug regimen. Because a large number of long-term care residents are full-benefit dual eligibles, it is important for the transition process that plans employ to account for any issues associated with filling the first prescription of a non-formulary drug. CMS has also developed ways to assist long-term care facilities in identifying the plan in which their dual eligible residents are enrolled to allow for early

accommodations to new formularies, if necessary. In addition to using the web-based Prescription Plan Finder tool at www.Medicare.gov for individual resident inquiries, long-term care facilities without Internet access or who need Medicare prescription drug plan enrollment information for multiple residents can now do so via a special CMS fax-based procedure.

II. Ensuring continuity of prescription drug coverage and care for the dual eligibles.

A. Outreach & Partnerships – CMS has conducted targeted education and outreach to ensure dual eligible beneficiaries are aware of the upcoming changes to their prescription drug coverage, including the transition in coverage, auto-enrollment, and their individual rights. CMS is conducting an integrated education effort incorporating both paid and earned multi-media, direct mail, and extensive grassroots operations organized down to the county level. This effort is run in cooperation with thousands of trained traditional and non-traditional partners across the country, including other federal agencies, state and local governments, pharmacists, nursing homes and other health care providers, faith-based organizations, and community based organizations.

B. Auto-enrollment – To ensure that there is no lapse in prescription drug coverage for full dual eligibles; CMS will make sure that full-benefit dual eligibles are enrolled in a Medicare prescription drug plan by January 1, 2006. In November, anyone who was a dual eligible for even one month beginning in March, 2005 received a letter which informed them of their new plan and the option to choose another plan. Dual eligible individuals also will have the opportunity to switch plans at any time. This ensures continuity of care when Medicaid prescription drug coverage ends, while also retaining the personal right to select a plan that best meets their needs. If a beneficiary is unaware of the plan in which they have been auto-assigned he/she can call 1-800-MEDICARE or look at the “Medicare Prescription Drug Plan Finder” on www.medicare.gov. In the future, we will identify and auto-enroll those about to become full-benefit dual eligibles prior to the end of their Medicaid coverage to ensure a seamless transition on an on-going basis. This includes those Medicaid beneficiaries who will age into Medicare, or who will reach the end of the 24-month Medicare disability waiting period.

C. Targeted Assistance – CMS will have special protocols and specially trained operators and case work coordinators ready to provide dual-eligibles focused assistance in January for any questions or concerns that may arise. We will track any issues and act on them quickly. CMS will work closely with States and with our many partners around the country to ensure that dual eligibles have a smooth transition to Medicare drug coverage.

D. Collaboration with States – CMS is committed to working with States on an ongoing and collaborative basis to ensure both the immediate need of a smooth transition for their current dual eligible residents is met and a continuing basis ensuring a successful transition for Medicaid beneficiaries who age into Medicare, the newly dually eligible individuals. This work commenced in August 2004 with convening of the State Issues Workgroup which included representatives from State Medicaid Agencies, the Social Security Administration and CMS. In addition to the ongoing efforts of the State Issue Workgroup, CMS engaged the

States in a series of summits, conference calls and workshops to discuss and work through the implementation issues of the MMA. Finally, CMS has worked especially closely with states on ensuring their monthly data feed identifying full-benefit dual eligible individuals to CMS is complete and accurate. CMS has a nationally recognized expert in Medicaid data validate each state's monthly feed, and the number matched consistently exceeds 99%.

E. Automatic Eligibility Checks and Coordination of Benefits in Pharmacies – In unprecedented coordination with all segments of the pharmacy and prescription drug payer industries, CMS has participated in the development of an automated Part D eligibility query and coordination of benefits (COB) process. The new eligibility capability will allow pharmacies to use existing pharmacy systems to identify a Medicare beneficiary's plan billing information, which will save pharmacists time and money in processing prescriptions for Medicare beneficiaries. This billing information will also allow pharmacists to immediately coordinate benefits with any other coverages the beneficiary may have through other payers, even if the beneficiary does not present the plan ID card or is even aware that he/she has been auto-enrolled into a Part D plan. These services will be open and accessible by all pharmacies regardless of the network or pharmacy management system they use.

F. Point of Sale Protection – CMS is making its best effort to identify and auto-enroll all dual-eligible beneficiaries prior to the effective date of their Part D eligibility. However, it is possible that some beneficiaries may go to pharmacies before they have been auto-enrolled in a Part D plan. For this reason, CMS has developed a process for a point-of-sale solution to ensure full dual eligible individuals experience no coverage gap when Part D coverage commences.

If a beneficiary presents at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D plan, the beneficiary will be able to leave the pharmacy with their prescriptions and a CMS contractor, which will be announced later today, will immediately follow up to validate eligibility and facilitate enrollment into a Part D plan.

CMS and its contractor will provide a uniform and straightforward set of instructions that all pharmacists can follow no matter which plan network they are in or where they are in the country. To achieve this objective, CMS is contracting with a single national plan to manage a single national account for payment of prescription drug claims for the very limited number of dual eligible beneficiaries who have not yet been auto-enrolled into a Part D plan at the time they present a prescription at the pharmacy.

For further detail about this additional component of the dual transition work plan please click here: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=6248

